BEFORE THE
RESPIRATORY CARE BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: ROBERT M. VALENZUELA 24836 Tigris Lane Hemet, CA 92544	Case No.: R-2104 OAH No.: 2007100671

DECISION AND ORDER

The attached proposed Decision of the Administrative Law Judge is hereby adopted by the Respiratory Care Board of California, Department of Consumer Affairs, as its Decision in the above entitled matter.

This Decision shall become effective on June 20, 2008.

It is so ORDERED June 13, 2008.

Original signed by:
LARRY L. RENNER, BS, RRT, RCP, RPFT
PRESIDENT, RESPIRATORY CARE BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

BEFORE THE
RESPIRATORY CARE BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation against ROBERT M. VALENZUELA, R.C.P., Respiratory Care Practitioner License No. 18345, Respondent.	Case No. R-2104 OAH No. 2007100671

PROPOSED DECISION

Administrative Law Judge Joyce A. Wharton, Office of Administrative Hearings, State of California, heard this matter on April, 14, 15, 16 and 17, 2008, in San Diego, California.

Douglas Lee, Deputy Attorney General, represented complainant Stephanie Nunez, Executive Officer of the Respiratory Care Board of California.

Don G. Grant, Attorney at Law, represented respondent Robert M. Valenzuela, who was present.

The record remained open for submittal of one exhibit, which was received on April 22, 2008. The matter was submitted on April 22, 2008.

FACTUAL FINDINGS

1. Robert Mills Valenzuela, hereinafter "respondent," was issued Respiratory Care Practitioner License, Number 18345, by the Respiratory Care Board of California on October 27, 1995. The certificate is renewed and current with an expiration date of October 31, 2008. There is no record of disciplinary action against this certificate.

2. On September 25, 2007, Stephanie Nunez, hereinafter "complainant," acting in her official capacity as Executive Officer of the Respiratory Care Board of California, signed and filed Accusation No. R-2104 against respondent. Complainant alleges cause for

discipline under Business and Professions Code[1] sections 3750, subdivision (f), negligence in his practice as a respiratory care practitioner, and 3755, unprofessional conduct in administering respiratory care.

Respondent filed a timely Notice of Defense and request for hearing. At the hearing respondent withdrew his affirmative defense based on the statute of limitations set forth in Section 3750.51, subdivision (a).

3. Respondent received his respiratory care training at Crafton Hills College in Yucaipa, California. He graduated with an Associate of Arts degree in 1998. As a student, respondent worked at several hospitals in Riverside and San Bernardino. He is certified as a Pulmonary Function Technologist.

Respondent has been employed as a respiratory care therapist (RCP) at St. Bernardine Medical Center in San Bernardino, California, since December 1998. He has broad experience working in all departments of the hospital. In 2000, respondent was assigned a supervisory position as lead therapist and continues in that position. He is responsible for assessing the work load, delegating assignments, and working as the respiratory care therapist in every department of the hospital. On days when he is not acting as supervisor, respondent spends most of his time in the ICU. In 2002, respondent was experienced in providing respiratory care to post cardiac surgery patients in the ICU.

Respondent has never been subject to any complaint by any of the hospitals for which he has worked or patients he has treated. There is no evidence that respondent has been the subject of any lawsuit for professional negligence.

4. Respondent was a very credible witness. He was professional in appearance and demeanor. His answers were candid, straightforward and responsive. He displayed a depth of knowledge about respiratory care and a strong sense of his responsibilities as a hospital therapist. There was no evidence to suggest that respondent is less than a very competent and caring respiratory care therapist.

5. The pending charges are based on respondent's care of one patient on March 30, 2002. Patient U.G. was in the cardiac ICU after undergoing coronary artery bypass surgery. Respondent was the respiratory therapist assigned to U.G. during the 7:00 a.m. to 7:00 p.m. shift on March 30, 2002.

6. Patient U.G., a 60-year-old male, was admitted to the Intensive Care Unit at St. Bernardine Medical Center on March 26, 2002. He had experienced symptoms of a heart attack for approximately 24 hours before going to the hospital. He underwent left heart catheterization and coronary angiogram on March 28, 2002, and a coronary artery bypass grafting on March 29, 2002.

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[1] All subsequent statutory references are to the California Business and Professions Code unless otherwise noted.

At 11:30 a.m. on March 29, 2002, U.G. was moved from the operating room to the ICU. He was orally intubated on a ventilator and received one-on-one nursing care in the ICU. In addition to the chart notes, the ICU nurse kept a flow sheet to record the patient's vital signs every 15 minutes, including temperature, blood pressure, pulse and respiration rate. A pulse oximeter constantly measured the patient's oxygen saturation rate, which the nurse recorded once per hour.

7. On March 29, 2002, pursuant to the hospital's normal protocol, the responsible physician issued the Post Open Heart Surgery Anesthesia Management Orders (Fast Track) for U.G. The orders included direction for taking the patient's arterial blood gases (ABG's). It was the responsibility of the respiratory care therapist to draw the blood to test for ABG's. The test determines the blood level of oxygen, carbon dioxide and acidity and is used to determine the patient's ability to sufficiently breathe and ventilate.

The Initial Ventilator Orders included the requirement to take ABG's at specified times during the process of weaning the patient from the ventilator and before removing the ventilator tube ("extubation"). The orders for after extubation specified "ABG's as needed for respiratory distress." Respiratory distress is the condition where the patient is not inhaling or exhaling sufficiently to maintain an appropriate oxygen level. There is nothing on the physician's order that requires an ABG test be done one hour after extubation.

8. At 7:00 a.m. on March 30, 2002, the ICU nurse noted that U.G. was unable to follow commands and had periods of extreme agitation. Gregory Misbach, M.D., was the assistant surgeon at U.G.'s bypass surgery and was responsible for his postoperative care. The hospital records indicate that Dr. Misbach saw the patient between 7:00 and 8:00 a.m., and gave orders for medication and weaning the patient from the ventilator.

9. On March 30, 2002, respondent began his daytime shift at St. Bernardine Medical Center at 7:00 a.m. His first contact with U.G. was at 8:40 a.m. after he had reviewed the patient's report. Respondent verified that the ventilator was operating properly and that the settings matched the physician's order. He assessed the patient, listened to breath sounds and recorded the information provided by the cardiac monitors. He noted that the night respiratory therapist had already begun the process of weaning U.G. from the ventilator.

Respondent's chart notes reflect that U.G. was selectively cooperative and responsive, the ventilator and alarms were properly set and functioning, the bag mask was at bedside, and the endotrachial tube was secure. Respondent also noted the breath sounds were clear bilaterally and the secretions suctioned were normal.

Respondent continued the weaning process by changing the ventilator to CPAP[2] mode in order to test the parameters of the patient's spontaneous breathing. The CPAP mode

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[2] CPAP means "continuous positive airway pressure." It is a mode on the ventilator that allows the patient to breathe spontaneously while the ventilator holds a positive pressure to keep the lungs open. It is used during the weaning process to evaluate how effectively the patient can breathe on his own.

allows the patient to breathe on his own with minimal support from the ventilator. Respondent charted the patient's response to CPAP and noted there was no respiratory distress observed. He left the patient on CPAP mode for a trial period.

10. Respondent checked and recorded the patient's respiratory status at 10:25 a.m. He did not observe the patient to be in respiratory distress.

11. Respondent drew blood for an ABG at 11:20 a.m. The blood gas report contained the comment that U.G. had been on CPAP for three hours with no respiratory distress noted, and that the patient was very agitated and aggressive. Respondent checked and recorded U.G.'s respiratory status at 11:25 a.m.

12. The nurse's note for 11:40 a.m. indicates U.G. would not take a deep breath. At 11:40 a.m. respondent changed the patient from CPAP to the full ventilator mode because he did not think U.G. was breathing sufficiently on his own. Respondent wanted Dr. Misbach to evaluate the patient at bedside before going forward with extubation. Dr. Misbach was in surgery, but respondent expected him to come to the ICU as soon as he finished. At noon, the nurse noted the patient continued to exhibit extreme agitation.

13. At 1:40 p.m., respondent checked and recorded the patient's respiratory status. At 2:00 p.m., Dr. Misbach was at bedside to evaluate the patient's condition. Respondent was also at bedside. Respondent provided Dr. Misbach with the information regarding U.G.'s respiratory status, including the patient's history of agitation, the CPAP trial results and the ABG results. Respondent and the nurse discussed the patient's condition with Dr. Misbach. Dr. Misbach ordered that U.G. be extubated and be given Valium and morphine to reduce agitation.

Complainant does not contend that Dr. Misbach's decision to extubate the patient was improper.

14. At 2:10 p.m., respondent began the extubation process. The nurse noted that U.G. continued to be restless and agitated. Valium was administered at 2:10 p.m., morphine at 2:15 p.m. and again at 2:30 p.m.

Respondent documented the extubation process in his chart notes as follows:

> "Dr. Misbach at bedside with order to extubate. Pt endotrache suctioned and orally suctioned for 0 return. Endo tube tape removed and pilot balloon deflated. Pt extubated and placed on 6 liters per minute nasal canula. SpO2 = 89-90%. Pt placed on 12 liters per minute S.M., SpO2 = 95-96%. Pt is very restless and agitated. Breath sounds checked for clear bilaterally with no strider or respiratory distress noted."

15. Respondent explained that after extubation he would have waited five to ten minutes with U.G on the nasal canula to assess its effectiveness. For the canula to work sufficiently the patient must breathe through his nose. Because U.G. was restless and agitated he was breathing more through his mouth than his nose, thus the oxygen saturation

rate was lower at 89 – 90%. Respondent then replaced the canula with a simple mask to deliver the oxygen. The saturation rate increased to a satisfactory level of 95-96%.

The evidence established that it would take 20 to 30 minutes to complete the steps necessary for extubation of an agitated patient such as U.G. Respondent estimated that the time taken to extubate U.G., evaluate the use of the canula, then apply and evaluate the face mask, would have kept him at bedside from about 2:10 p.m. to shortly before 3:00 p.m. The nurse was also present most of time recording the vital signs and administering medications. The nurse noted that at 3:00 p.m. U.G. was sleeping.

16. Respondent had other patients to care for on March 30, 2002, including several on ventilators. He did not remain constantly at U.G.'s bedside between 3:00 p.m. and 4:00 p.m.; as the RCP, he was not required to do so. There was no evidence the ICU nurse felt the need to contact respondent about any change in U.G.'s respiratory status.

17. At 4:00 p.m. on March 30, 2002, respondent was at U.G.'s bedside administering an IPPB[3] treatment. This treatment helps the patient begin to take deep breaths on his own. Respondent explained that this treatment would normally take 10 to 15 minutes on a receptive patient, but it may have been longer with U.G. because he was not cooperative.

After the IPPB treatment, at approximately 4:15 to 4:30 p.m., the nursing staff was changing U.G.'s bed linens when he became extremely combative and uncontrollable. Several people, including respondent, tried to keep U.G. still to prevent him from pulling out his chest tubes. U.G. was sitting up, leaning forward and fighting with staff, when he suddenly leaned back against the mattress. Respondent looked at U.G. and checked the cardiac monitor. U.G. did not appear to be breathing and the heart rate was slowing. Respondent immediately unlocked the bed, pulled it from the wall, and instructed the nurse to get the intubation equipment. Respondent applied the bag mask to U.G. and began ventilating the patient with 100% oxygen. He took an ABG at 4:31 p.m. while U.G. was on the bag mask. Dr. Misbach was called and was immediately at bedside. Respondent reintubated U.G. and placed him back on the ventilator

18. The hospital record contains the following note by Dr. Misbach regarding the event:

> ". . . after breathing treatment and changing bed linen pt extremely agitated and requiring 4 people to restrain him as he tried to pull out chest tubes. Pt then had rapid decline in resp rate to zero and then bradycardia, hypotension and probable cardiac arrest. No femoral pulse palpable when I came into room and pt being mask ventilated and pacer on. CPR started, pt intubated by resp therapist, 1 amp Epi given IV and 1 to 2 min later pt had excellent femoral pulses without CPR and BP soon 230/130 with HR 230. Slowly declined to HR 140 and BP 210/110. . . ."

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[3] IPPB means "Intermittent Positive Pressure Breathing."

19. The evidence did not establish the cause of this event or the ultimate condition of U.G. as a result of this event. There was no evidence to suggest that an ABG taken after extubation would have provided information to prevent or mitigate this event.

20. Complainant alleges two instances of negligence and/or unprofessional conduct. She contends that respondent was required to perform an ABG test approximately one hour after extubating the patient, but failed to do so. She contends the patient suffered declining cardio-pulmonary status, specifically, respiratory distress after extubation, and respondent failed to inform the registered nurse or the physician about this condition.

21. Donald J. Broman, RCP, is the Director of Respiratory Care Services at St. Bernardine Medical Center. He has been a Registered Respiratory Care Therapist in California since 1975, and a Certified Pulmonary Function Technologist since 1985. Mr. Broman has worked at St. Bernardine since 1974. He served as Director of Cardiopulmonary Services from 1998 to 2001. From July 2001 to the present, he has been Director of Respiratory Care.

Mr. Broman explained that the ICU nurses are the primary eyes for the physician. In addition to the one-on-one care, there was electronic monitoring of cardiac status and a pulse oximeter to measure oxygenation saturation, with alarms set to alert the nurse if the respiratory rate or saturation are outside set parameters. There was no expectation that respondent would remain with the patient or perform constant monitoring after extubation. As Directory of Respiratory Care, Mr. Broman expects the RCP to communicate with the nurse about the patient's condition after extubation and then go to care for his other patients. If there was a respiratory problem, the nurse had a beeper to locate respondent.

Mr. Broman addressed the temporary decrease in U.G.'s oxygen saturation rate immediately after extubation. He explained that it is not unusual for the saturation rate to drop when the patient is removed from the ventilator and begins to breathe room air with the nasal canula oxygen. Respondent evaluated this and corrected it by changing to the simple mask, which raised the saturation to 95-96%. This process was successful and there was no need to inform the physician.

Mr. Broman has been familiar with respondent's abilities and performance as an RCP since respondent began working at St. Bernardine's. He has observed respondent to be an excellent therapist – competent and proactive in caring for patients. He considers respondent to be one of the more knowledgeable RCP's.

The Expert Witnesses

22. Complainant called Lisa Miller, RCP, to testify. Ms. Miller has been a registered Respiratory Care Practitioner in California since 1978 and has been licensed in California since 1985. She obtained a B.A. degree in Criminology from U.C. Berkeley in 1974. In 1977, she received an A.A. degree in Respiratory Care from Skyline College in San Bruno, California.

From 1978 to 1985, Ms. Miller was the Lead Pediatric Specialist, Respiratory Care, at Stanford University Medical Center. From 1985 to 1987, she was the Respiratory Care Pediatric Specialist at Mercy General Hospital in Sacramento. Ms. Miller took time away from her professional activities to raise a family between 1987 and 1998. From 1998 to the present, she has worked as RCP and Respiratory Patient Assessment Coordinator at Mercy General Hospital in Sacramento. This work includes evaluation and coordination of respiratory care for adult floor and ICU patients, liaison for physicians and staff, ABG puncture and analysis, and teaching patients and staff. From 2001 to the present, Ms. Miller has worked as a Consultant Educator at Catholic Healthcare West, Mercy Learning Center in Sacramento. Although she currently works with post-open heart surgery patients, she has not actively worked with these patients in the ICU since 1985. She has served as an expert reviewer for the Respiratory Care Board since 2002.

23. Respondent called Lorra Browne, RCP, to testify. Ms. Miller has been a registered Respiratory Care Practitioner in California since 2001. In 1993, she received her A.A. degree in respiratory care from Des Moines Area Community College in Iowa. Ms. Browne worked as a certified respiratory care therapist at three hospitals in Iowa: Trinity Regional Hospital in Ft. Dodge from 1993 to 1995; Green County Medical Center in Jefferson from 1995 to 1999; and Stewart Memorial Community Hospital in Lake City from 1999 to 2001. After moving to California, she worked as a RCP at Hoag Memorial Presbyterian Hospital in Newport Beach from 2001 to 2002, and at Saddleback Memorial Medical Center in Laguna Hills from 2002 to 2004. Her experience includes working with post-surgery cardiac patients but she gave no information about the extent of her experience with those patients in the ICU. From 2004 to the present, Ms. Brown has held the position of Manager of Cardiopulmonary Services at Orange Coast Memorial Medical Center in Fountain Valley. Her oversight covers clinical and operational services including cardiac, neurological and pulmonary diagnostics, and inpatient and outpatient respiratory care.

24. Respondent called William P. Klein, M.D., F.C.C.P., F.A.C.P., to testify. Dr. Klein is a licensed California physician with board certifications in internal medicine and pulmonary disease. Dr. Klein graduated from Dartmouth College in 1962. He received his M.D. from State University of New York Downstate Medical Center in 1966. He performed his internship and residency in internal medicine at the State University of New York, Kings County Hospital, in Brooklyn, and Bronx Municipal Hospital Center in the Bronx. In 1972, he completed a Fellowship in Pulmonary Medicine at Bronx Municipal Hospital.

Dr. Klein has served as Clinical Professor of Medicine, UC Irvine Medical Center, Division of Pulmonary and Critical Care Medicine from 1993 to the present. Since 1978, he has been the Directory of Respiratory Therapy at Humana Hospital Huntington Beach, where he is also the current Director of the Pulmonary Function Laboratory and the Pulmonary Rehabilitation Program. He holds staff privileges at Fountain Valley Regional Medical Center, UCI Medical Center, Hoag Memorial Hospital Presbyterian, Irvine Regional Hospital and Orange Coast Memorial Medical Center.

Negligent Acts

25. Ms. Miller offered her opinion that respondent deviated from the standard of care when he failed to obtain an ABG within the hour after extubation. She explained that the standard of care was established by the Post Open Heart Surgery Anesthesia Management Orders at Item 12 which required "ABG's as needed for respiratory distress." Ms. Miller cited no authority and gave no medical reason for a mandatory ABG one hour after extubation of patient U.G.

Ms. Miller offered her opinion that U.G. showed signs of respiratory distress after extubation and respondent should have done an ABG at 3:10 pm. Ms. Miller pointed to the nurses' notes and the flow chart to show instances of elevated heart rate, pulse, blood pressure, respiration and continuing agitation to support her conclusion of respiratory distress. However, she also acknowledged that these fluctuating numbers could have been caused by other factors such as pain, discomfort with the breathing tube, extended agitation or a condition beyond the scope of her practice. She admitted that agitation and low oxygen saturation can be caused by something other than respiratory distress.

Ms. Miller's opinions about respondent's negligent acts were not persuasive. She had little, if any, experience in caring for patients immediately after heart surgery in the ICU. She was mistaken in her understanding of several background facts because she relied on the recitations in a report prepared by a Medical Board consultant regarding Dr. Misbach's care, rather than making her own careful review of the hospital record. Her conclusion that U.G. suffered respiratory distress shortly after extubation was based on reading selected chart notations without considering the entire clinical picture of the patient, such as what U.G. was doing at the time of a spike or decrease, and without considering that the symptom could be caused by factors other than respiratory distress. In asserting that an ABG should have been done at 3:10 p.m., she did not take into account that the extubation was not completed until after 2:30 p.m.

26. Lorra Browne, RCP, offered her opinion that the standard of care did not mandate an ABG one hour after extubation of patient U.G. She explained that one hour after extubation is the minimum – not the maximum - time that should pass before an ABG is done. The standard is to let at least one hour pass before the ABG, if one should be done at all. This allows the patient to stabilize after the extubation procedure. Based on her review of the records, it was Ms. Browne's opinion that U.G. did not suffer respiratory distress while he was on the ventilator, being weened from the ventilator or during the relevant time after extubation. She explained that pulse oximetry is the standard alternative to the more invasive ABG for testing oxygenation. She saw nothing in the patient's chart that would lead respondent to conclude U.G. was in respiratory distress and required an ABG before the rapid onset of the cardiopulmonary event. It was Ms. Browne's opinion that respondent's response to that event was completely appropriate and within the standard of care.

27. Dr. Klein offered his opinion that the standard of care did not require respondent to do an ABG one hour after extubation and respondent's failure to do a post-extubation ABG was not negligent. He explained that the results of the ABG drawn at 11:40

a.m. showed the patient was not in respiratory distress. In 2002, there was no standard that required an ABG one hour after extubating a post-cardiac surgery patient. The standard of care required a clinical evaluation of the patient at bedside. The RCP must consider everything happening with the patient in evaluating the clinical significance of the data obtained from monitoring. Dr. Klein found no failure of judgment or evaluation by respondent. He saw nothing in U.G.'s record to cause respondent to determine U.G. was in respiratory distress. The standard of care required respondent to use his clinical judgment and he did so.

28. Ms. Miller offered her opinion that respondent deviated from the standard of care because he did not relay information about the status of the patient to either the ICU nurse or the physician during the time after extubation to the time of the cardiopulmonary event at 4:30 p.m. Her opinion does not consider that the ICU nurse was constantly checking and recording the patient's condition. Ms. Miller did not seem to know that respondent had requested Dr. Misbach to evaluate U.G. before going forward with extubation and had provided all the information about the patient's respiratory status. Ms. Miller's testimony on cross-examination was inconsistent with her opinion. She conceded that once U.G. was placed on the simple mask his oxygen saturation rates were acceptable and there was no need to tell Dr. Misbach either that the rate had been 89-90% with the canula or that he had switched to the simple mask. She agreed that, from the time Dr. Misbach examined the patient at 2:10 p.m., and was aware of the trends in vital signs until the event at about 4:30 p.m., there were no significant changes in blood pressure, respiration rate, pulse, temperature or oxygen saturation that would require notifying the physician.

29. Ms. Browne offered her opinion that respondent did not violate the standard of care by failing to communicate U.G.'s status to the nurse or the physician. Based on her review of the medical record, she found that respondent was very available to Dr. Misbach and the nurse before, during and after extubation. She found communication ongoing and noted consistency in the documentation by the three health care professionals.

Dr. Klein found no failure by respondent to communicate important patient information to Dr. Misbach or the nurse. Dr. Misbach and the ICU nurse were fully aware of U.G.'s cardiopulmonary status when Dr. Misbach evaluated the patient at 2:10 p.m. on March 30, 2002, and gave the order for extubation. It was Dr. Klein's opinion that U.G. did not exhibit a declining cardiopulmonary status between the time of extubation and the rapid onset of the event at 4:30 p.m. Dr. Klein found no significant change in U.G.'s clinical status that respondent should have, but did not, communicate to either the nurse or Dr. Misbach.

30. The evidence established that, in 2002, there was no standard of care that required respondent to perform an ABG test on patient U.G. one hour after extubation. The evidence did not establish that on March 30, 2002, U.G. suffered respiratory distress warranting an ABG after extubation and before the cardiopulmonary event at 4:30 p.m.

The evidence did not establish that, on March 30, 2002, patient U.G. exhibited a declining cardiopulmonary status that required respondent to communicate with the physician or nurse and that respondent failed to do so.

The evidence failed to meet the standard of clear and convincing, or even a mere preponderance, to establish that respondent was negligent in his treatment and care of patient U.G.

31. The evidence did not establish that, in his care and treatment of patient U.G., respondent committed repeated acts of clearly administering directly or indirectly inappropriate or unsafe respiratory care procedures, protocols, therapeutic regimens, or diagnostic testing or monitoring techniques.

The evidence failed to meet the standard of clear and convincing, or even a mere preponderance, to establish that any aspect of respondent's care and treatment of patient U.G. on March 30, 2002, constituted unprofessional conduct.

32. Except as set forth in the Factual Findings above, the factual allegations of the Accusation were not established by evidence that was clear and convincing to a reasonable certainty and they are deemed surplusage. Expert opinions elicited at the hearing on matters not alleged in the Accusation are not relevant and cannot support a finding of negligence or unprofessional conduct.

33. The evidence established that complainant incurred costs of investigation and prosecution of the case in the amount of $18,762.50.

LEGAL CONCLUSIONS

1. The standard of proof in an administrative hearing to revoke or suspend the license of a Respiratory Care Practitioner is clear and convincing proof to a reasonable certainty and not a mere preponderance of the evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) The burden rests with the complainant to offer proof that is clear, explicit and unequivocal – so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*In re Marriage of Weaver* (1990) 224 Cal.App.3d 478; *In re Michael G.* (1998) 63 Cal.App.4th 700.) The standard is not met if the totality of the evidence serves only to raise concern, conjecture or speculation. The complainant bears the burden of presenting sufficient evidence to, first, establish the relevant standard of care and, second, prove respondent's conduct that fell below that standard. When the complainant fails to meet this initial burden, the respondent need not present evidence to refute the unproven charges.

2. Cause was not established to discipline respondent's license for negligence in his practice as a respiratory care practitioner in violation of section 3750, subdivision (f). This conclusion is supported by Factual Findings 1 through 32 inclusive, and Legal Conclusion 1.

3. Cause was not established to discipline respondent's license for unprofessional conduct in violation of section 3755. This conclusion is supported by Factual Findings 1 through 32 inclusive, and Legal Conclusions 1 and 2.

4. Complainant is not entitled to recover the costs of the investigation and prosecution of this case pursuant to section 3753.5. This conclusion is supported by Factual Findings 1 through 32 inclusive, and Legal Conclusions 1, 2 and 3.

ORDER

The Accusation is dismissed.

DATED: 5/13/08

JOYCE A. WHARTON
Administrative Law Judge
Office of Administrative Hearings